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Can My Advance Directives Travel Across State Lines?

An Essay on Portability

by Charlie Sabatino

America is a very mobile society. Not only do we move around a lot, many are willing to travel to get health care, especially for complex, specialty treatment. How well do our wishes travel with us across state lines and across health systems? The documentation of our health care wishes has come to be most associated with statutory advance directive documents, typically health care powers of attorney and living wills. These documents tend to be tethered to one's state of residence, because the content and formalities of execution of the documents are defined and regulated by state law. These laws are as varied as the geography of the states.

It's important to keep in mind that statutory advance directives are not the only game in town. There are any number of possible non-statutory modes of communication that can function as an advance directive. These may take the form of less formal writings by the individual such as a letter to family members, answers written in any of a growing number of advance care planning workbooks, statements recorded on video, or documented discussions with one's health care providers. Any expression of one's future wishes about health care is an advance directive in its broadest sense.

Background on Statutory Advance Directives

Most state advance directive laws were intended to provide one clear pathway the public could use to document their wishes, not to eliminate all other avenues. These other avenues may be more valuable or less valuable as guidance than a formal advance directive, yet most policy and practice focuses almost exclusively on statutory directives. Statutory advance directives have the aura of state authority and provide a perk that physicians seem to value—statutory immunity for complying with their patients' directives. While immunity may have been an effective carrot for changing physician behavior in the 1970s and 80s, it should be irrelevant in today's world where advance care planning and person-directed care have become the expected standard of care. Given this legislative landscape, any discussion about the portability of advance care planning documents naturally starts with statutory directives.

Jane and Joe want to know if the advance directive they complete in their home state—let's pick one at random… Illinois—will be recognized and honored in other states. This question comes up with unceasing frequency. The usual answer is that it should be recognized and honored since most, but not all, states have provisions explicitly validating out-of-state

advance directives. Of course, every detail-conscious lawyer will add that it all depends on the state; and if one spends a good deal of time in a second state, the usual advice is to have a lawyer from the second state look at it.

In reality, there are no reported cases, virtually no research, and few word-of-mouth stories of refusals by health care providers to honor an advance directive from a different state. But, that fact doesn't mollify the concern that people have about the portability of their advance directives. Moreover, given the universal public policy in favor of advance care planning by all adults, it seems incongruous that states are so Balkanized in the mechanics of creating and implementing advance directives in the first place. As a lawyer, I would like to be able to assure a client that she can use any advance directive that resonates with her and it will be valid and honored in every state.

In 2005, I published an article that took one advance directive that sought to be used nationally—the *Five Wishes* advance directive—and held it up to the law of all 50 states and the District of Columbia to see if it could possibly work nationally.[1] If Jane and Joe used *Five Wishes* then, our conclusion was that it would probably be considered valid in 36 states and D.C. The other 14 states posed requirements that made it difficult, if not impossible, for *Five Wishes* or any other single form to work in all states as a statutorily recognized form. Interestingly, in the intervening years, some states have somewhat simplified their laws such that *Five Wishes* form now claims to be usable in 42 states and D.C. That's progress but not a state of universal friendliness to the concept of a national advance directive.

[1] Sabatino, Charles P., "National Advance Directives: One Attempt to Scale the Barriers," 1 NAELA Journal 131 (2005).

Possible Policy Approaches to Portability

There are a number of possible policy pathways to portability of advance directives, each with its advantages and disadvantages. One is through the simplification and conforming of state law nationally, such that it becomes feasible to meet the requirements of all states in a single form. This is the route tested by the *Five Wishes* exercise. This is also the route promoted by the Uniform Law Commission which adopted a very simple Uniform Health-Care Decisions Act in 1993. Unfortunately, only seven states have adopted the act (Alaska, Delaware, Hawaii, Maine, Mississippi, New Mexico, and Wyoming), and even then, only with their own home-grown variations. Considering the politics of state law-making, sufficient uniformity across the states seems unlikely.

Another road to portability is the conventional path traveled by states, which relies on language in statute recognizing the validity of out-of-state directives if: (1) they are valid in the state where executed or (2) if they meet the requirements of the state where treatment is delivered. Two problems arise under this approach. One is that health providers cannot practically assess whether the directive meets the legal requirements of another state, unless a lawyer follows them around all day. If Jane and Joe spend winters in Arizona, what does Joe's cardiologist in Arizona know about Illinois law?

As a result, some states add a presumption of validity unless the provider has knowledge to the contrary. That certainly helps, but it doesn't solve a second problem. Even if legally recognized, the directive may not be interpreted in the way the maker of the document intended, because the definition of terms and rules for implementing the document vary across states. Jane and Joe's Illinois advance directives

name each other as primary health care agents with complete authority to make all health care decisions. In Illinois, health-care means "any care, treatment, service or procedure to maintain, diagnose, treat or provide for the patient's physical or mental health or personal care."[2]

If Jane and Joe go across the border to Wisconsin, a simple statement of authority to make "health-care" decisions comes with a couple caveats. In Wisconsin, it does not include authority to consent to the withholding or withdrawal of a feeding tube or long-term admission to a nursing home, unless the advance directive *explicitly* authorizes those decisions.[3] In other words, two things Jane and Joe could consent to in Illinois, they can't in Wisconsin, even though their directives are valid there. They would have needed to comply with the special language requirements of Wisconsin law to have their wishes interpreted as they intended. Thus, the conventional approach of recognizing the validity of out-of-state documents falls short.

A third road to portability is through national legislation. A little known provision in federal law already makes one category of advance directives valid everywhere. In 1996, Congress enacted a federal advance directive option solely for military personnel that explicitly preempts state law.[4] Recommendations for a federally created national advance directive for the public at large have occasionally been pondered but have never been formally proposed in legislation. States' rights concerns make this a long-shot, since health care decision-making has traditionally been seen as primarily the province of state law.

Given the barriers to a federally created national advance directive, proponents have pursued legislative strategies that seek only to address portability itself, but how to do this has its own challenges. The most obvious route is through Medicare and Medicaid, since in order to participate in those programs, providers must comply with federal standards. Federal law could replicate the conventional state approach by requiring providers to consider out-of-state directives valid if they are valid in the state where executed or if they meet the requirements of the state where treatment is delivered. A presumption of validity would be important to include, also. This would be a very modest step forward but with the same limitations as described above.

If a federal provision went a step further to *require* compliance with an out-of-state directive, then difficult questions arise about the exact parameters of federal preemption. Suppose the law of the state where treatment is delivered provides for conscience objections by which providers can refuse to comply with an individual's documented wishes as a matter of conscience. Would the federal portability provision override that? Delineating the exact parameters of preemption is more difficult than may be initially thought.

An Alternative: Focus on Respecting Individual Wishes, not on Validating Documentation

A simpler way to approach portability may be to avoid the narrow focus on validating formal advance directives and to focus on honoring the wishes of Jane and Joe no matter how they express them. In 2005, the state of Idaho provided an example of one way to do this with one simple sentence in its advance directive law: "Any authentic expression of a person's wishes with respect to health care should be honored."[5] Under this provision, the inquiry moves away from determining the validity of the advance directive to determining the person's wishes, regardless of how expressed.

Some will shudder at the prospect of possible argument over what is authentic or how to interpret vague expressions of wishes. But those concerns arise even with statutory advance directives. There are no cookbook instructions for end-of-life decisions. More importantly, the Idaho provision accurately affirms long-standing common law and constitutional principles of self-determination and liberty in the context of health care decision-making. We too easily forget that statutory advance directives were created as one way to effectuate those principles, not to box them in to a single pathway. Another advantage of the Idaho provision is that it makes no difference whether the person is out-of-state or in-state; their wishes, no matter how communicated, are strengthened. This does not eliminate differences in how a state may interpret particular words, such as in the Illinois-Wisconsin example above. But, it does make portability a non-issue.

[2] 755 Ill. Comp. Stat. Ann. 45/4-4.

[3] Wisc. Stat. Ann. § 155.20 (West 2016).

[4] 10 U.S. Code § 1044c.

[5] Idaho Code § 39-4508(3) (West 2016).

This approach has gained attention in at least one federal proposal in the 114th Congress. In 2016, representatives Earl Blumenauer (D-OR) and David Roe (R-TN) cosponsored the *Personalize Your Care Act 2.0* which addresses several aspects of advanced illness management and advance care planning.[6] Its portability language echoes Idaho's: "In the absence of a validly executed advance directive, any authentic expression of a person's wishes with respect to health care shall be honored."

One other state besides Idaho also chose this route in amending its advance directive law. A 2016 Maryland amendment to its health decisions law states: "Notwithstanding any other provision of law, in the absence of a validly executed or witnessed advance directive, any authentic expression made by an individual while competent of the individual's wishes regarding health care for the individual shall be considered." While the mandate to "consider" is less powerful than to "honor," it still turns the focus toward the goals, priorities, and wishes of the individual, rather than on the particular form used.

[6] H.R. 5555.

Conclusion

The value of this any-kind-of-expression approach is a freeing up of the process of advance care planning so that it can flow from the personal communication style, culture, and comfort level of each individual, ideally in dialog with loved ones and health care providers. In contrast, the legal paradigm, built upon precise formalities of execution, prescriptive language, and technical definitions, has been user-friendly only for a minority of the public. That is likely one of the reasons why, after over three decades of promoting advance directives, only about a third of adults have them today. Humans are a varied bunch. Jane and Joe are unique in biology, personal history, culture, education, and in a thousand other ways. Their preferred mode of communicating their wishes may be quite different from yours or mine or the one dictated in their state's advance directive law. That's why we need the flexibility to allow a thousand approaches to advance care planning.

Charles P. Sabatino is the Director of the ABA Commission on Law and Aging in Washington, DC. ■

American Bar Endowment Opportunity Grants Program

The American Bar Endowment (ABE) has adopted an Opportunity Grants Program, to support smaller, innovative programs and projects by eligible grantees that fit within the mission of the ABE. The ABE is prepared to award up to $200,000 in one or more grants. The Opportunity Grant is intended to be a one-time award to start or enhance a program of law-related research, education, or public service projects. The ABE will consider grant applications from 501(c)(3) entities for projects that meet the focus requirements set out in the Program Goal. It is expected that a program or project receiving an Opportunity Grant will become self-sustaining. The application process is streamlined to encourage proposals from a broad range of organizations.

Program Goal

The goal of the Opportunity Grants program is to assist eligible grantees in the development or enhancement of innovative programs and projects that address issues of immediate and critical interest to the public and members of the legal profession. Examples of areas of focus include: rule of law initiatives, access to justice initiatives, civics education on the American legal/justice system, and legal services initiatives.

ABE Contact

To obtain an application form, visit: http://www.abendowment.org/pdf/OppGrant-Application.pdf. Additional guidance may be requested from the ABE at:

American Bar Endowment
321 North Clark Street, 14th Floor
Chicago, Illinois 60654-7648
Attention: Opportunity Grants
800-621-8981, ext. 6408 or 312-988-6408
jmartin@abendowment.org

Grant applications must be submitted to the ABE by November 30, 2016, for consideration. To learn more, visit http://www.abendowment.org/about/opportunity.asp. ■

Memo to SRC

Re Witnesses and Notarization for Advance Directives

Date: October 30, 2020

SRC approved a subcommittee to study the question of changes in the Advance Directives law to ease the signing of Advance Directives. Pre-covid attorneys sometimes had issues with obtaining witnesses for clients who are residents of long-term care facilities or in a medical facility. Post-covid access to clients in such facilities or hospitals has proven difficult to non-existent.

Current Colorado law requires only the witnessing of advance directives. The committee initially developed a proposal (Option 1) that would allow for either the witnessing or notarization of advance directives. Use of the notary only would be consistent with the current Colorado will execution statute.

Post-covid the committee has developed a proposal (Option 2) that would accept signature of a client with no requirement for either witnesses or a notarization. This is a procedure allowed in a small number of states and is consistent with the Uniform Health-Care Decisions Act which provides that a directive may be either written or oral.

Option One

An Act to make the witnessing and notarization of Advance Medical Directives (Living Wills) and Medical Powers of Attorney consistent with current requirements for witnessing and notarizing Last Wills.

15-18-106, Colorado Revised Statute is amended to read:

15-18-106. WITNESSED OR NOTARIZED DECLARATION

Except as otherwise provided in section 15-18-105, a declaration shall EITHER BE;

(a) Signed by the declarant in the presence of two witnesses. The witnesses shall not include any person specified in section 15-18-105; OR

(b) SIGNED BY THE DECLARANT AND ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR OTHER INDIVIDUAL AUTHORIZED BY LAW TO TAKE ACKNOWLEDGMENTS WHO IS NOT A PERSON SPECIFIED IN SECTION 15-18-105.

15-18-104(5), Colorado Revised Statute is amended to read:

(5) A declaration executed IN ACCORDANCE WITH SECTION 15-18-106 by any adult with decisional capacity shall be legally effective for the purposes of this article.

EFFECTIVE DATE APPLICABILITY – NEW SECTION

(1) THIS ACT TAKES EFFECT ON _____.

(2) THIS ACT APPLIES TO GOVERNING INSTRUMENTS EXECUTED BEFORE, ON OR AFTER THE EFFECTIVE DATE.

Idaho Statutes

Title 39. HEALTH AND SAFETY

Chapter 45. THE MEDICAL CONSENT AND NATURAL DEATH ACT

Current through Chapter 341 of the 2020 Regular Session

§ 39-4507. FORM OF CONSENT

It is not essential to the validity of any consent for the furnishing of hospital, medical, dental or surgical care, treatment or procedures that the consent be in writing or any other specific form of expression; provided however, when the giving of such consent is recited or documented in writing and expressly authorizes the care, treatment or procedures to be furnished, and when such writing or form has been executed or initialed by a person competent to give such consent for himself or another, such written consent, in the absence of convincing proof that it was secured maliciously or by fraud, is presumed to be valid for the furnishing of such care, treatment or procedures, and the advice and disclosures of the attending physician or dentist, as well as the level of informed awareness of the giver of such consent, shall be presumed to be sufficient.

Cite as Idaho Code § 39-4507

Option Two

An Act for the optional witnessing and notarization of the signature of the declarant of an Advance Medical Directive (Living Will) or Medical Power of Attorney

15-18-106, Colorado Revised Statute is amended to read:

15-18-106. WITNESSED OR NOTARIZED DECLARATION

Except as otherwise provided in section 15-18-105, a declaration SIGNED BY THE DECLARANT MAY BUT IS NOT REQUIRED TO BE EITHER;

(a) Signed by the declarant in the presence of two witnesses. The witnesses shall not include any person specified in section 15-18-105; OR

(b) SIGNED BY THE DECLARANT AND ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR OTHER INDIVIDUAL AUTHORIZED BY LAW TO TAKE ACKNOWLEDGMENTS WHO IS NOT A PERSON SPECIFIED IN SECTION 15-18-105.

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